RFS 7-99
SOLICITATION FOR INSURANCE PROVIDERS
ATTACHMENT E

PLAN DESCRIPTION AND COVERED BENEFITS

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1.0 Overview of the Program

Under the health care coverage plan established under House Bill 1678 (the "Program"), participating Plans will deliver a basic benefit package offered through a deductible health plan. The deductible health plan includes up to $500 of "first dollar" coverage for preventative services and will be paired with a personal health care account referred to as a POWER (Personal Wellness and Responsibility) Account. The POWER Account will be funded with, at minimum, State and individual contributions. Members will use POWER Account funds to meet the deductible of their health plan. Although vision and dental services are not covered services under the Program, members will have an opportunity to purchase vision and dental coverage from their Plan.

The Program is designed to provide incentives for participants to stay healthy, be value- and cost-conscious and utilize services in a cost-efficient manner. Goals of the Program include:

- **Prevention:** Encourage Hoosiers to seek preventative care
- **Peace of Mind:** Offer health coverage to thousands of uninsured Hoosiers
- **Personal Responsibility:** Give individuals control of their health care decisions and incentivize positive health behaviors
- **Cost and Quality Transparency:** Make individuals aware of the cost of health care services and the quality of available providers

2.0 Eligible and Excluded Populations

As provided in IC 12-15-44, individuals of at least 18 years of age and less than 65 years of age are eligible for the Program if their annual household income is not more than 200% of the Federal Poverty Level (FPL). Additional eligibility criteria for the Program includes: U.S. citizenship and 12-months of state residency. Individuals must also be uninsured for at least six (6) months prior in order to be eligible for the program.

The following individuals are not eligible for the Program:

- An individual who participates in the federal Medicare program
- An individual who is eligible for Medicaid as a disabled person
- An individual who has access to an employer-sponsored health plan
- An individual who is currently enrolled in a health insurance program

Deleted: , with the exception of pregnant women receiving pregnancy-related services under Hoosier Healthwise Package B

3.0 The Delivery System

Both accident and sickness insurers and health maintenance organizations (HMOs) (collectively, the "Plans") may contract with OMPP to provide covered services and administer the POWER Account. Plans contracting with OMPP are responsible for claims processing and must reimburse providers at a rate not less than 1) Medicare reimbursement or 2) 130% of Medicaid rates if the service does not have a Medicare reimbursement rate. Plans will manage care through a comprehensive contracted network of PMPs, specialists and other providers. Plans may not deny coverage to an eligible individual who has been approved by DFR to participate in the Program, unless the individual has exceeded the Program's annual or lifetime coverage limits.

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The State requires the Plan to initiate network development. To confirm the Plan's provider participation, the State will evaluate the Plan's progress in its network development efforts prior to the start date of the contract.

Section 5.0 of Attachment D to this RFS provides further detail regarding Provider Network Requirements.

4.0 Enrollment in the Program

As described in Section 4.1 of Attachment D to this RFS, the primary path for enrollment in the Program will be through the Plans. When an applicant applies for the Program through a Plan, the Plan will forward the application materials to the Division of Family Resources (DFR). DFR will make a final eligibility determination within 45 days of receiving completed application materials, including supporting documentation, and will forward its determination to the Plan. The plan selection and required POWER Account contribution amount calculation will also be processed in this timeframe.

Individuals will also be able to apply for the Program at any local DFR office, as well as other authorized enrollment locations, such as hospitals and health clinics. If an individual applies for enrollment in another FSSA program, such as Hoosier Healthwise, but does not qualify, the applicant will be screened for eligibility in the Program. Parents that are enrolling their children in SCHIP will be provided information about the Program.

The State is currently in the process of outsourcing its front-end application processing functions for all FSSA programs. The new application system will be rolled-out on a regional basis, and the goal is that this system will be fully operational by mid-2008. Under the new system, individuals will be able to apply for the Program and other FSSA programs by completing a web-based application or by contacting a central Call-In Center. Individuals will also be able to mail or fax application materials to a central Document Center. Plans will be able to access these application processing options when helping individuals sign up for the Program.

Section 4.1 of Attachment D to this RFS provides further detail regarding Member Eligibility and Enrollment.

5.0 Provider Networks

The Plan must ensure that its provider network is supported by written agreements, is available, is geographically accessible and provides adequate numbers of facilities, physicians, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members. All providers rendering services to the Plan's members must be enrolled with the Indiana Health Coverage Programs (IHCP), including out-of-network providers and providers that are located out-of-state. Providers must agree to comply with all IHCP regulations and State standards regarding access to care and quality of services. Additionally, all laboratory providers must hold Clinical Laboratory Improvement Amendments (CLIA) certificates.

Further information about IHCP Provider Enrollment is located at:

http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp

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5.1 Provider Types

Each Plan must have a network comprised of the Plan's contracted providers. The network must include PMPs as well as specialty providers. The network must also include hospitals, pharmacies and ancillary providers.

PMPs, specialists, hospitals, pharmacies and ancillary providers may contract with more than one Plan providing services under this RFS.

See Section 5.0 of Attachment D to this RFS for more information on provider network composition requirements.

5.2 Primary Medical Care Providers (PMPs)

The Plan must assure that each member has an ongoing source of primary care appropriate to the member's needs. This includes a person or entity formally designated as primarily responsible for coordinating the health care services provided to the member. OMPP requires Plans to provide access to primary care within at least 30 miles of the member's residence.

A PMP must be in the field of general practice, family practice, general internal medicine or gynecology. Certain medical services must not require prior authorization by PMPs or the Plan, i.e., self-referral services. See Section 2.1 of Attachment D to this RFS for more information about Self-Referral Services. PMPs may provide information to members about how to access self-referral services and may advise members of self-referral providers that are available to render these services.

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6.0 Covered and Non-Covered Services

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Covered benefits under the Program include physician services, mental health care and substance abuse services, inpatient and outpatient care, emergency room services, urgent care services, preventative care services, family planning services, hospice services, prescription drugs, durable medical equipment, diagnostic services and therapies, disease management and home health. The annual per person benefit maximum is $300,000. The lifetime per person benefit maximum is $1,000,000. Vision and dental services are excluded from the Program, but Plans must provide members the opportunity to purchase vision and dental coverage, as set forth in Section 2.4.2 of Attachment D to this RFS. As stated in IC 12-15-44-4, the Plan must comply with any coverage requirements that apply to an accident and sickness insurance policy issued in Indiana.

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The attached table provides a general list of the Program's covered services and limitations. Plans are encouraged to cover additional programs and services that enhance the general well-being and health of its members.

Excluded services and benefits in the Program's basic benefit package are as follows:

- Maternity and related services

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- Dental services including extraction, restoration and replacement of teeth, x-rays, supplies, appliances and all associated supplies with the exception of an accidental traumatic injury to natural teeth. In such cases, treatment must be sought within 48 hours of the injury.
- Conventional or surgical orthodontics or any treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly
- Vision services
- Elective abortions and abortifacients
- Non-emergency transportation services
- Chiropractic services
- Long term or custodial care including domiciliary, convalescent care, skilled nursing facilities used for long-term care and custodial care, nursing home care, home-based respite care, group homes, halfway homes, residential facilities
- Experimental and investigative services. Experimental and investigative services include those procedures and services that are not consistent with accepted standard medical practice or services not approved by the governing bodies. The Plan has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to experimental and investigative services.
- Any services which are not deemed to be medically necessary as determined by the Plan
- Day care and foster care
- Personal comfort or convenience items not limited to air purifiers, allergenic items (e.g. pillows, mattresses, waterbeds, etc.). Humidifiers, physical fitness equipment, air conditioners, treadmills or any other item deemed as a personal comfort item by the Plan.
- Cosmetic services, procedures, equipment or supplies. Cosmetic services are primarily intended to preserve, change or improve appearance or for the improvement of psychiatric or psychological reasons. Complications directly relating to cosmetic services, treatment or surgery are not covered. Benefits are available if treatment for reconstructive service is performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies or previous medically necessary procedure.
- Hearing aids, including any associated services for the fitting or prescription of hearing aids
- Safety glasses, athletic glasses and sunglasses
- LASIK and any surgical eye procedures to correct refractive errors
- Vitamins, supplements and over-the-counter medications
- Wellness benefits other than smoking cessation
- Diagnostic testing or treatment in relation to infertility
- In vitro fertilization
- Gamete or zygote intrafallopian transfers
- Artificial insemination
- Reversal of voluntary sterilization
- Transsexual surgery
- Treatment of sexual dysfunction including but not limited to medication
- Ear piercing
- Over-the-counter contraceptives
- Physician samples dispensed in a physician’s office

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- Alternative or complementary medicine including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, reike therapy, massage therapy, herbal, vitamin or dietary products or therapies
- Treatment of hyperhydrosis
- Court ordered testing or care unless medically necessary
- Travel related expenses including mileage, lodging and meal costs
- Missed or canceled appointments for which there is a charge
- Services and supplies provided by, prescribed by, or ordered by immediate family members including spouses, parents, siblings, in-laws or self
- Services and supplies for which member has no legal obligation to pay in absence of this or like coverage
- The evaluation or treatment of learning disabilities
- Foot care, with the exception of diabetes foot care, that is deemed routine including cutting or removal of corns, calluses, nail trimming, and cutting. Foot care that is hygienic and preventative maintenance
- Surgical treatment of the feet to correct flat feet, hyperkeratosis, metatarsalgia, subluxation of the foot, and tarsalgia
- Any injury, condition, disease ailment arising out of the course of employment IF benefits are available under any Worker's Compensation Act or other similar law
- Examinations for the purpose of research screening

Plans must offer members chronic disease management programs that cover the following conditions: Diabetes, Congestive Heart Failure, Asthma and Chronic Kidney Disease. Plans are also welcome to offer additional disease management programs to members.

The amount, duration and scope of covered benefits and services under the Program, as well as self-referral services and excluded benefits, may be described in greater detail in program manual(s) that will be released prior to the implementation date of a contract awarded under this RFS, as well as future administrative rules established under IC 12-15-44.

Section 2.0 of Attachment D to this RFS also provides detail regarding Covered Benefits and Services.

6.1 Vision and Dental Services

Vision and dental services are not part of the Program's basic benefit package; however, Plans will be required to offer vision and dental insurance riders for purchase by their members. The member will pay 50% of the premium cost, up to 5% of the member's income. The State will pay the remaining premium cost for the vision or dental insurance rider.

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The optional vision benefit rider must cover vision exams and hardware, including contacts. The dental care services optional benefit rider must cover comprehensive dental benefits.

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Benefit/Description		Limitations/Co-Pay	
Inpatient Facility	**Medical/Surgical** .		
	Mental Health/Substance Abuse	Covered same as any other illness.	
	Skilled Nursing Facility	Excludes custodial care	
Outpatient Facility	**Surgery**		

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	Benefit/Description	Limitations/Co-Pay	
	Emergency Room	Childless adults will be subject to a $25 co-payment for all ER visits, both emergencies and non-emergencies. Parents will also be subject to co-payments according to the following schedule: • < 100% FPL - $3 • 100-150% FPL - $6 • 151-200% FPL - $25 However, the Plan must refund co-payments paid by parents in the case of a true emergency, as determined by the prudent layperson standard. This is not true for childless adults.	
	Urgent Care		
	Physical/Occupational/Speech Therapy	25 visit annual maximum for each therapy	
	Radiology/Pathology		
	Pharmacy and Blood		

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Benefit/Description		Limitations/Co-Pay	
	Cardiovascular		
Professional Services	**Inpatient/Outpatient Surgery**		
	Inpatient/Outpatient/ER Visits		
	Office Visits/Consults		
	Preventative Services, includes immunizations, flu shots, annual physicals (including diagnostic services), pap smears, mammograms, routine prostate antigen tests, colorectal cancer exam/laboratory testing, smoking cessation counseling and nicotine replacement therapy (prescription only)		
	Physical/Occupational/Speech Therapy	25 visit annual maximum for each therapy.	
	Cardiovascular		
	Radiology/Pathology		
	Outpatient Mental Health/Substance Abuse	Covered same as any other illness.	
Ancillary Services	**Prescription Drug**	Please see Section 2.10 of Attachment D. Subject to certain exceptions, brand name drugs are not covered where a generic substitute is available.	

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Benefit/Description		Limitations/Co-Pay	
	Home Health/Home IV Therapy	Excludes custodial care. Includes case management.	
	Ambulance	Emergency ambulance transportation only, subject to the prudent layperson standard.	
	Durable Medical Equipment/Supplies/Prosthetics	Hearing aids are excluded.	
	Hospice		
	Comprehensive Disease Management		
	Family Planning Services	Excludes abortion or abortifacients. Includes contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 USC 1396, et seq.).	